Next steps for continuity of care: practical learning in light of the Fuller report

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General practice is facing significant and multiple challenges, driven by a perfect storm of COVID-19, GP shortages and workload pressures. The impact on patients is obvious – and this is reflected in dramatically falling satisfaction levels.

The recent Fuller report offered a clear vision of the future primary care system, including the fundamental ingredients that need to stay, where change needs to happen and what can enable that change.

One of those fundamental ingredients is continuity of care, which we at the Health Foundation have long championed. Since 2019 we've worked with the Royal College of General Practitioners to support five projects focused on improving relational continuity – the ongoing relationship between practitioner and patient – in general practice. This programme (Increasing Continuity of Care in General Practice) stands on the shoulders of a well-established evidence base of the benefits to patients and staff of continuity of care.

What have we learned about continuity of care?

Despite the disruption caused by COVID-19, each of these five funded projects reported that they had maintained or improved continuity against a backdrop of falling continuity in England.

Now the programme has come to an end, and in light of the Fuller report, I'm pleased to share some common themes from the evaluation of this work to increase continuity of care. This blog sets out our learning not only about what it takes to improve continuity in practice now, but also about opportunities for how it can be a central part of modern general practice in the future.

1. Continuity where it is important

A key point made in the Fuller report is that not everyone wants or needs continuity. While impressive work is happening to offer continuity to all patients, we saw encouraging results from Valentine Health Partnership using a targeted approach. They focused on continuity for patients who were usually healthy, but reporting new and changing symptoms. The Valentine team found that the 60–65% of patients targeted for enhanced continuity reverted to lower levels of GP attendance.

This highlights the importance of a data-driven approach to identify alternative cohorts of patients that can benefit from continuity of care, in addition to those with multiple long-term conditions and complex needs.

2. Continuity of care and timely access are not necessarily opposing principles

It's a challenge to balance continuity of care and timely access, especially given the COVID-19 backlog and workforce pressures. Fuller makes the important point that different patients will have different priorities. By setting up the right infrastructure and workflows, practices can work with patients to ensure they get the kind of access they prefer, that can include seeing their named or preferred GP.

The programme evaluation highlighted ways in which practices can help patients work through their access and continuity priorities. For example, receptionists suggesting non-urgent consultations are booked with the patient's named GP. Public engagement also led to patients taking ownership and asking for their preferred GP, encouraging a more positive relationship between continuity and access.

Against a backdrop of a policy and political push to prioritise urgent GP access, the programme evaluation showed that only 15% of patients at the project sites were not willing to wait longer to see their preferred GP. As Fuller indicated, there is still more work to do to get the balance right between immediate access and continuity of care, but the learning from the programme

indicates that it can be done, and in a way that centres the needs and preferences of patients.

3. Measuring continuity can be complex but is the first step to improving it

Fuller rightly says that continuity is 'one of the core strengths of primary care', but we should not underestimate how challenging it is to measure, and therefore improve. We heard from project sites that current systems do not always support measurement for continuity. There are ways of working around this: For example, Morecambe Bay Primary Care Collaborative used a robotic programme to develop a dashboard to help practices measure and understand levels of continuity over time. However, future plans to make the Fuller report a reality should consider how IT and infrastructure systems work with general practice to enable continuity, rather than being a barrier that needs to be overcome.

Improving continuity in practice

While the Fuller report outlines an exciting vision for primary care, unsurprisingly but crucially, the key question is 'how?'. Improving continuity is possible, but it is not without its challenges.

Morecambe Bay Primary Care Collaborative and One Care CIC produced an in-depth, practical online toolkit to improving continuity, drawing on quality improvement methods and approaches, and real-world examples. It is designed to guide practices through their continuity improvement journey. Health care professionals, working with patients, can adopt and adapt tried and tested resources from those who have successfully improved continuity in practice.

At a time where GP capacity is particularly precious, the toolkit and learning from this programme can offer practical insights on how continuity of care can continue to be a key pillar of general practice in the future.

As primary care looks to build on the Fuller stocktake, alongside dealing with multiple significant challenges, there is an opportunity to explore how continuity – and its benefits for patients and staff – can be embedded into new and emerging models of care.

The final independent programme evaluation will be available in autumn 2022.

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http://alumni.health.org.uk/news-and-comment/blogs/next-steps-for-continuity-of-care-practical-learning-in-light-of-fuller